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DEPARTMENT OF THE INTERIOR
UNITED STATES BUREAU OF MINES
JOHN W. FINCH, DIRECTOR

INFORMATION CIRCULAR

COAL-MINE FATALITIES IN ALABAMA

1931-34

BY

FRANK E. CASH

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By Frank E. Cash[2]

INTRODUCTION

Although during the past 10 years Alabama has attained an enviable position by its coal-mine accident experience and, like most of the other coal-mining States, has made progress in the safer operation of coal mines, there is still room for improvement, which can be realized only by still greater efforts on the part of employees and employers.

From 1893, when accidents were first recorded by the Alabama State Mine Inspection Department, to 1934, inclusive, 3,451 men lost their lives in the production of 569,722,676 tons of coal.

The primary purpose of this report is to bring to the attention of the mining industry in Alabama and elsewhere statistics of fatal accidents for 1931-34, with the hope that a study of the causes may lead to reduction of similar accidents in the future.

ACKNOWLEDGMENTS

The data in this report on coal production and the occurrence and investigation of fatal accidents in Alabama were made available by the State Mine Inspection Department through the cooperation of W. B. Hillhouse, Chief Mine Inspector, and his staff, to whom the author expresses his appreciation.

PRODUCTION AND FATALITIES

Although detailed discussion of fatal accidents is confined to the 4 years 1931 to 1934, table 1 includes statistics available on production and fatalities by years and causes from 1893 through 1934 compared with similar figures for the United States.

Of the 3,451 fatal accidents that occurred in the coal mines of Alabama during the past 41 years falls of roof and coal caused 1,328 (38.5 percent);

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gas and dust ignitions and explosions, 1,056 (30.6 percent); haulage, 498 (14.5 percent); electricity, 232 (6.7 percent); explosives, 139 (4.0 percent); machinery, 46 (1.3 percent); and other or miscellaneous causes, 152 (4.4 percent).

Comparison of causes of the fatal accidents for Alabama with those for the United States on a basis either of production or of man-hours of exposure reveals that gas and dust ignitions and explosions rank much higher and falls of roof and coal lower in Alabama.

FATALITIES, 1931-34

With due respect to the efforts to reduce mine accidents made before 1925, the real fight for their prevention began in 1925 and 1926. During these 2 years alone 12 gas and dust ignitions or explosions resulted in the death of 107 men. The united efforts of mine operators and employees, the Holmes Safety Association, the Alabama Mine Inspection Department, the Alabama Mining Institute, and the United States Bureau of Mines in promoting safety education, closer examination of mine air for explosive gas, air sampling, improved ventilation, application of rock dust in or throughout mines and water at working faces, and increased use of electric cap lamps and permissible explosives, led to marked reduction of accidents from gas and dust which has been maintained, with further reduction, through 1934.

During 1927 the same agencies concentrated their efforts on reduction of accidents from falls of rock and coal, and in 1928 haulage and electrical accidents were included; the results are reflected very favorably in the Alabama coal-mine accident experience for 1930-34, as indicated in table 1.

INVESTIGATION AND DESCRIPTION OF FATAL ACCIDENTS

The Alabama State Mine Inspection Department makes thorough investigations of mine accidents, places the responsibility, and calls attention to recommendations in previous inspection reports and bulletins which, if complied with, would have prevented the accidents. During 1930, 1931, and 1932 (or until the personnel of the Department was materially reduced) a comprehensive sketch was made at the place of each fatal accident, and copies were furnished all operating officials and posted on all mine bulletin boards. It is regrettable that this practice had to be discontinued, as its effect on the reduction and prevention of accidents was of inestimable value.

The State Mine Inspection Department did not publish annual reports from 1929 to 1934, due to reduced appropriations, but the detailed accident experience before 1931 was published by the United States Bureau of Mines3/

This report is confined to fatal accidents by years, causes, etc., as recorded by the State Mine Inspection Department for 1931 through 1934; data describing the causes and nature of the accidents, and responsibility therefor are condensed from the individual reports.

3/ Cash, F. E., Accident Reduction in Alabama Coal Mines: Inf. Circ. 6191, Bureau of Mines, 1929, 9 pp. Safety in Connection with Haulage Practices in Alabama Coal Mines: Inf. Circ. 6243, Bureau of Mines, 1930, 11 pp. Cash, F. E., and Humphrey, H. B., Explosions in Alabama Coal Mines: Inf. Circ. 6352, Bureau of Mines, 1930, 8 pp. Fatalities in Alabama Coal Mines: Inf. Circ. 6354, Bureau of Mines, 1930, 14 pp. Lost-Time Accidents in Some Alabama Coal and Iron Mines During 1930: Inf. Circ. 6506, Bureau of Mines, 1931, 7 pp. Fatal Accidents in Alabama Coal Mines During 1930: Inf.Circ.6519, Bureau of Mines, 1931, 8 pp.

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TABLE 1. - Production and fatalities in Alabama coal mines, 1893-1934

Year	Production, tons	Fatalities from							Total fatalities	Tons per fatality	Tons per fatality United States
		Falls of rock and coal	Haulage	Electricity	Machinery	Explosives	Gas and dust	Miscellaneous			
1893	5,270,042	16						1	17	310,000	
1894	4,361,312	10	2			1	5	1	19	229,200	
1895	5,705,713	22	6		1	2	6	2	39	150,150	
1896	5,745,617	18	4			2		4	28	205,201	
1897	5,893,771	18	3		2	3	9	3	38	151,122	
1898	6,466,741	24	9		1		10	1	45	143,705	
1899	7,484,778	21	7			4	6	2	40	187,119	
1900	8,273,362	19	4			3	2	9	37	223,603	
1901	8,970,617	24	6			6	2	3	41	218,186	
1902	10,329,479	29	9		2	10			50	206,590	
1903	11,700,753	22	6			3	18	8	57	205,276	
1904	11,273,151	38	7			3	26	10	84	135,204	
1905	11,900,153	34	8	1		4	131	8	186	64,325	
1906	12,851,775	50	12	6	6	7	13	2	96	133,873	
1907	14,424,863	34	16	4		6	82	12	154	93,668	
1908	11,523,299	39	16	10		12	9	22	108	106,697	
1909	13,790,268	70	17	4		10	26	2	129	106,901	
1910	16,139,228	55	20	6	1	10	139	7	238	67,812	
1911	15,011,853	47	14	6		5	130	7	209	71,827	186,887
1912	16,513,040	61	16	7	1	5	25	6	121	136,471	220,945
1913	17,907,284	68	19	5		2	27	3	124	144,413	204,685
1914	15,525,903	55	24	11	1	1	34		126	123,222	209,261
1915	15,266,831	23	18	8	1	4	8	1	63	242,331	234,297
1916	18,234,625	28	15	9	2	3	59	2	118	154,531	265,094
1917	20,413,811	52	26	9	5	2	12	2	108	187,298	241,618
1918	19,521,840	58	23	4	2	5	10	8	110	177,437	262,873
1919	15,928,196	36	18	9	1	2	24	3	93	171,277	238,464
1920	17,391,437	34	15	4	2	6	13	4	78	222,967	289,729
1921	13,015,017	38	12	12	2	8	7	1	80	162,668	253,832
1922	18,757,681	46	14	7	1	1	112	2	183	102,501	240,399
1923	20,919,303	44	19	9	3	2	8	4	89	235,014	267,223

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TABLE 1. - Production and fatalities in Alabama coal mines, 1893-1934 (Continued)

Year	Production, tons	Fatalities from							Total fatalities	Tons per fatality	Tons per fatality United States
		Falls of rock and coal	Haulage	Electricity	Machinery	Explosives	Gas and dust	Miscellaneous			
1924	19,615,931	39	9	16	1	5	3	4	77	254,752	237,974
1925	20,408,656	49	19	11	2	7	65	9	162	125,979	260,461
1926	21,508,812	42	31	18	4		42	2	139	154,739	261,241
1927	20,190,926	61	15	8	2	1	3	3	93	217,106	267,978
1928	18,056,116	28	17	13	4	4		1	67	269,494	264,749
1929	18,415,914	28	19	11			12	2	72	255,667	278,380
1930	16,007,376	34	5	11	2	1	8	0	61	262,416	263,839
1931	12,126,400	7	9	2	2	1	3	2	26	466,400	301,938
1932	8,280,000	12	2	4					18	460,000	297,900
1933	9,000,000	10	7	4			1		22	409,091	378,255
1934	9,600,792	14	11	3		1	2	1	32	300,250	
1893 to 1934	569,722,676	1,328	498	232	47	140	1,056	150	3,451		

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Fatalities in 1931

In the production of 12,126,400 tons of coal in 1931, 26 fatalities resulted from the following causes: Haulage, 9; falls of roof and coal, 7; gas and dust, 3; electricity, 2; machinery, 2; explosives, 1; and miscellaneous, 2.

Haulage

1. On March 13, 1931, at 4:30 p.m., a colored carpenter, 24 years old, was injured by derailment of a locomotive and cars on an entry haulageway and died 7 days later. He was single and had no dependents. The deceased was riding the rear end of the locomotive when the derailment occurred, and he was caught between the locomotive and a car. His right leg was crushed and his left leg fractured.

Responsibility for this fatality rests on the motorman for driving the locomotive at an excessive rate of speed.

2. On March 16, 1931, at 4:15 p.m., a colored miner, 42 years old, was crushed by the derailment of a car on the main haulageway, and his pelvis and right leg were fractured; he died 4 hours later. He was married and had no dependents. The deceased was sitting on a pipe line along the main haulageway, when a car in a passing trip was derailed at a switch, crushing the deceased between the car and rib.

Responsibility for this fatality rests on the foreman for allowing men to congregate on the main haulageway and on the deceased for not waiting in the shelter hole provided.

3. On May 22, 1931, at 3:30 p.m., a colored driver, 35 years old, was crushed between a car and the rib on entry haulage, receiving injuries resulting fatally 24 hours later. He was married and had one dependent. The accident occurred while the deceased was spragging a car.

Responsibility for this fatality rests on the company for not providing adequate clearance and upon the deceased for violating instructions in pulling more than one car.

4. On May 25, 1931, at 8:30 a.m., a colored motorman, 32 years old, was killed when a main haulage locomotive he was operating was derailed, crushing him between top rock, rib, and locomotive. He was married and had no dependents.

Responsibility for this fatality rests on the deceased for operating a locomotive at an excessive rate of speed.

5. On May 31, 1931, at 11:30 p.m., a white shift leader, 45 years old, while riding a loaded slope trip received a fractured spine, which resulted fatally 2 days later. He was married and had two dependents. The deceased was riding the front end of a slope trip and was caught between a curtain frame and the trip as the trip passed through the frame.

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Responsibility rests on the deceased, as it is a violation of the mining law to ride trips and he was in charge of the operation.

6. On July 16, 1931, at 9:30 a.m., a colored laborer (coupler), 37 years old, received fatal internal injuries when a loaded car ran over him. He was married and had two dependents. The deceased was pushing a front loaded car from a room, when the block became dislodged and the rear loaded car ran on him.

The responsibility for this accident rests on deceased for violating the mine rules by not properly blocking the car, and on the supervising official for not enforcing mine rules.

7. On July 17, 1931, at 4:00 p.m., a white coupler, 22 years old, was killed in a collision between loaded runaway cars and an empty trip. He was married and had no dependents. The deceased was riding third from front car in a pushed empty trip on the entry, when two loaded runaway cars collided with the empty trip, fracturing his skull and causing internal injuries.

Responsibility for this fatality rests on the supervising official for not seeing that standing cars on grades were properly blocked.

8. On September 8, 1931, at 5:45 p.m., a white motorman, 28 years old, had both legs crushed and died from his injuries 9 days later. He was married and had one dependent. A "flying switch" was being made on the main haulageway with 12 empty cars, which collided with a locomotive and loaded trip operated by the deceased.

Responsibility for this accident rests on the company for allowing "flying switches" to be made.

9. On September 28, 1931, at 3:00 p.m., a colored miner, 29 years old, received a fractured pelvis and internal injuries that caused death 2 hours later. He was single and had no dependents. Empty cars were being cut out in room necks for loading, when one car was wrecked, and another car ran back on the miner.

Responsibility for this fatality rests on the deceased's fellow-workman for not properly blocking the car and on the foreman for not enforcing mine rules relative to car blocking.

Falls of Roof and Coal

1. On January 7, 1931, at 2:00 p.m., a colored miner, 44 years old, was killed by a rock fall that fractured his skull. He was married and had no dependents. The deceased, who was working near the face of a room, was standing on a car bumper leveling coal in a car. A rock 2-1/2 inches thick fell, crushing his skull against the top of the car door.

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Responsibility for this fatality rests on the deceased for not setting timbers, on the foreman for not requiring timbers to be set, and on the company for not furnishing the proper size cap boards.

2. On February 13, 1931, at 1 p.m., a colored miner, 50 years old, received internal injuries that caused death 3 hours later. He was married and had no dependents. The deceased was shoveling coal from a room pillar when rock 7-1/2 feet long, 4-1/2 feet wide, and 3 to 18 inches thick fell as a result of insufficient timbering.

The responsibility for this accident rests on the foreman for not properly instructing the miner in regard to adequate timbering and on the deceased for not setting timbers properly for his own protection.

3. On June 24, 1931, at 11:25 a.m., a colored laborer, 52 years old, was killed by a rock fall, his body being badly crushed. He was single and had no dependents. After shooting a coal slab for a turn-out, the deceased was passing between car and rib when a rock 2-1/2 feet thick fell on him.

Responsibility for this fatality rests on the foreman for not having rock, which he knew was loose, taken down and on the contractor for not taking down or timbering the rock.

4. On July 3, 1931, at 12:15 a.m., a colored miner, 38 years old, was fatally crushed by a fall of rock. He was married and had four dependents. While the miner was loading coal at the face of a room, rock 7 feet long, 6 feet wide, and 7 inches thick which "rode" its supporting prop, fell on him, inflicting internal injuries.

Responsibility for this fatality rests on the deceased for not properly timbering the roof and indirectly on the section foreman for improper supervision.

5. On August 25, 1931, at 11:30 a.m., a white entry foreman, 26 years old, had his back broken by a fall of rock on the entry; he died from the injury 14 days later. He was married and had one dependent. The deceased was working as an extra driver when a rock 10 feet long, 4 feet wide, and 2 inches thick fell on him.

Gas and Dust

1, 2, and 3. On December 29, 1931, at 4:00 p.m., three colored laborers, two of them 25 years old and one 36 years, received burns in a gas ignition on a coal mell, which caused death 12 to 24 hours later. All of them were married, and two dependents were left. An ignition of accumulated methane from the controller of a nonpermissible mining machine caused burns that resulted fatally.

Responsibility for this accident rests on the company for improper conduction of ventilation and on the foreman (burned) for not making proper examination for methane before starting the machine.

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Electricity

1. On November 11, 1931, at 4:30 a.m., a colored laborer, 36 years old, was electrocuted. He was married and had one dependent. The deceased was getting a sandwich out of his dinner pail on the wire side of the entry when he came in contact with a 250-volt direct-current trolley wire.

Responsibility for this fatality rests on the company for not protecting the wire or for not providing adequate clearance on the side opposite the wire and on the deceased for eating under, or on, the trolley-wire side of the entry.

2. On December 11, 1931, at 10:30 a.m., a colored miner, 47 years old, was electrocuted. He was single and had no dependents. While the deceased was pushing a car from an entry into a room under the trolley wire, his head struck a 250-volt direct-current wire.

Responsibility for this fatality rests on the company for not moving or properly shielding the trolley wire where men have to work or pass under it.

Machinery

1. On January 14, 1931, at 10:30 a.m., a white carpenter, 52 years old, was caught by a revolving drive shaft in a washing plant and received injuries that were fatal 16 hours later. He was married and had two dependents. The deceased was repairing shielding on moving machinery and backed into the rotating drive shaft, breaking his right leg and several ribs on the left side and sustaining internal injuries.

Responsibility for this fatality rests on the foreman for allowing a man to work on moving machinery and on the deceased for not safeguarding himself.

2. On August 18, 1931, at 9:00 a.m., a white hoisting engineer, 22 years old, had his right arm torn from his body by an underground hoist, the injury causing death 7 hours later. He was single and had no dependents. The deceased was guiding loose rope on a drum with his hand, when his hand was caught between drum and rope.

Responsibility rests on the deceased for not protecting himself and properly spooling the cable using some tool rather than his hand.

Explosives

1. On April 6, 1931, at 2:30 p.m., a colored shot firer, 18 years old, was mangled and killed by an explosion. He was single and had no dependents. The deceased was carrying or dragging a box of explosives along a wall, and it is assumed that his carbide lamp fell into the box, causing detonation of 40 "caps" and 40 sticks of permissible explosives.

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Responsibility for this fatality rests on the company for allowing violation of the mining law and also for allowing the use of open lights in a coal mine.

Fatalities in 1932

In the production of 8,280,000 tons of coal in 1932, 18 fatalities resulted from the following causes: Falls of roof and coal, 12; electricity 4; haulage, 2.

Falls of Roof and Coal

1. On January 22, 1932, between 8:30 and 10:30 a.m., a white miner, 22 years old, was killed by fall of rock that crushed his skull. He was single and had no dependents. The deceased was working in a room and, it is supposed, was preparing to set a post under a "pot" when it fell. The rock was 4-1/2 feet long, 3 feet 10 inches wide, and 6 to 12 inches thick; at one time it had had a post under it.

Responsibility for this fatality rests on the deceased for not properly timbering for his own protection and on the company for allowing a man to work without proper supervision.

2. On February 3, 1932, at 11:30 a.m., a colored miner, 27 years old, received injuries that caused death 8 hours later. He was married and had one dependent. The deceased's body was crushed by a fall of rock in a room neck while he was passing over an empty car to reach the working face; the rock was 5 feet square and 14 inches thick.

Responsibility for this fatality rests on the foreman and on the deceased for not properly testing the roof.

3. On February 22, 1932, between 7:30 and 9:30 a.m., a colored miner, 35 years old, was killed when his entire body was crushed by a rock fall. He was married and had seven dependents. The deceased entered his room at 7:30 a.m. and was found at 9:30 a.m. under a rock 17 feet long, 6 feet wide, and 8 feet thick in the center, feathering in all directions.

Responsibility for this fatality rests on the deceased for violation of timbering rules - insufficient timbering; it is also poor safety policy to work one man alone in a room.

4. On April 14, 1932, at 5:00 p.m., a white chute rider, 24 years old, was killed when a fall of rock fractured his skull and broke his neck. He was single and had no dependents. The deceased was in a sitting position, pushing coal down a chute from a wall, when a rock 3 feet long, 2-1/2 feet wide, and 10 inches thick fell on him.

Responsibility for this fatality rests on the company, inasmuch as the timber requirements were inadequate.

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5. On April 26, 1932, at 12:30 a.m., a white shift leader, 25 years old, was killed when a rock fall crushed his body. He was single and had no dependents. The deceased, an experienced miner, was pulling pillars when a rock 7 feet long, 2 feet wide, and 14 inches thick fell on him.

Responsibility for this fatality rests on the company for not providing proper cap boards and closer inspection and supervision.

6. On June 25, 1932, at 4:30 p.m., a white boss driver, 31 years old, was killed by a fall of rock that fractured his skull. He was married and had two dependents. The deceased was riding the rear end of a loaded slope trip when a rock 21 feet long, 3 feet wide, and 5 inches thick fell on him.

Responsibility for this fatality rests on the deceased for violating the mining law relative to riding on loaded slope trips and on the company for failing to take down or timber dangerous rock over haulageways.

7. On September 13, 1932, at 3:30 p.m., a colored miner, 66 years old, was fatally injured when a fall of rock crushed his head and body; he died 8 hours later. He was single and had no dependents. While the deceased was loading coal on pillar work, top coal and draw slate fell on him. The main top was well-timbered.

Responsibility rests on the company for allowing a method to be used in mining that left overhanging coal and draw slate.

8. On September 18, 1932, at 5:30 a.m., while taking up coal left by a machine at the face of an air course, a white scraper, 24 years old, was killed by a fall of rock, which crushed his head. He was single and had no dependents. The rock should have been taken down before "scrapping" was begun.

Responsibility for this fatality rests on the company for allowing insufficient and inadequate timbering, improperly set, and on the shift leader and the deceased for working under such conditions.

9. On November 15, 1932, at 2:30 p.m., a white miner (day worker) 19 years old, was killed by a rock fall that crushed his body. He was single and had no dependents. The deceased was working on an entry pillar with his father, under weathered top, when a rock 8 feet long, 6 feet wide, and 1-1/2 inches thick fell on him. The roof was not properly timbered, although the foreman was in the place an hour before the accident.

Responsibility rests on the mine foreman for improper supervision of timbering.

10. On November 17, 1932, at 7:00 p.m., a white foreman, 42 years old, was killed by a rock fall on the main entry. He was married and had three dependents. The foreman had pulled down loose rib coal and sounded the top and was passing a standing trip when a rock 7 feet long, 6 feet

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wide, and 7 inches thick fell, catching him against the car and crushing his head.

Responsibility rests on the deceased because of misjudgment of the roof condition.

11. On December 4, 1932, between 1:30 and 6:00 p.m., a white contractor, 24 years old, was killed in a room neck by a rock fall that crushed his head and body. He was married and had no dependents. The deceased was in a heading that had been filled with water for 2 years, cleaning up a room neck to lay a track. At 1:30 deceased, who was working alone, told the motorman that no more cars would be needed; at 6:00 p.m., the machine crew found him under a rock 15 feet long, 11-1/2 feet wide, and 1-1/2 inches thick. It was known that the roof was bad.

Responsibility for this fatality rests on the company and on the deceased for disregarding safe timbering practices, and it is anything but safe to allow men to work alone doing dangerous work in a mine.

12. On December 23, 1932, at 12:30 p.m., a colored timber helper, 30 years old, was killed on a wall by a fall of rock. He was single and had no dependents. The miner discovered a "horseback" in the roof and called the timberman to take it down or set the necessary timbers. The timberman was getting a prop, and his helper was preparing a place to set it, when rock 5 feet long, 3-1/2 feet wide, and 2-1/2 inches thick fell, crushing the head and body of the helper.

Responsibility for this fatality rests on the timberman and on the deceased for not testing rock before working under it.

Electricity

1. On January 13, 1932, at 4:00 p.m., a colored coupler, 31 years old, was electrocuted. He was married and had four dependents. While rerailing wrecked cars on the slope, the deceased came in contact with a 250-volt direct-current trolley wire, which was 5 feet above and 6 inches outside of the rail.

Responsibility for this fatality rests on the deceased for not taking the proper precautions and on the company for allowing low, unshielded trolley wire.

2. On April 22, 1932, at 10:30 p.m., a white scraper, 24 years old, was electrocuted. He was single and had no dependents. While the deceased was transferring a machine by a locomotive at the intersection of an entry and slope, the trolley pole came off the wire, and in attempting to replace it, his head came in contact with the wire.

Responsibility for this fatality rests on the company for not properly shielding the trolley wire and for having the motorman's seat on the trolley-wire side of the locomotive.

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3. On May 23, 1932, at 11:20 p.m., a colored coupler, 24 years old, was electrocuted when his head struck the trolley wire. He was married and had one dependent. While the deceased was unloading ties on the main haulageway, his head came in contact with a 250-volt direct-current trolley wire. Artificial respiration was started 15 minutes later and was continued 3 hours and 10 minutes without results.

Responsibility for this fatality rests on the company for not raising or shielding the trolley wire where men had to work.

4. On December 13, 1932, at 4:10 p.m., a colored miner was electrocuted. After finishing the shift, the deceased was caused by water in the manway to walk on the rail on his way to the shaft. The 220-volt alternating-current conductor was 6 feet above the rail, and the victim must have stepped from one rail to the other, striking the wire with his hands.

Responsibility for this fatality rests on the company for not providing a safe manway and on the deceased for taking chances with electrical conductors.

Haulage

1. On November 28, 1932, at 2:00 p.m., a white miner, 32 years old, was killed on the entry by an empty car. He was married and had two dependents. While letting a loaded car out of a heading with sprags, the deceased struck an empty car in a room neck, which dislodged the scotch, and the empty car ran over him, crushing his head.

Responsibility for this fatality rests on fellow-workmen for improperly blocking cars and on the foreman for not enforcing the mine rule for blocking cars safely.

2. In December 1932 a colored coupler received a broken leg and internal injuries from which he died 2 weeks later. The deceased was crushed between wrecked cars on the entry.

Fatalities in 1933

In the production of 9,000,000 tons of coal in 1933, 22 fatalities resulted from the following causes: Falls of roof and coal, 10; haulage, 7; electricity, 4; gas and dust, 1.

Falls of Roof and Coal

1. On January 18, 1933, a white trackman, 40 years old, was killed by a rock fall. He was married and had four dependents. The deceased, an experienced timberman, was on special duty with the mine foreman and the assistant mine foreman removing cross collars and taking down loose rock on the entry, when a rock 7 feet long, 6 feet wide, and 3 inches thick fell on him, crushing his head and body.

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Responsibility for this fatality rests on the foreman, the assistant foreman, and the deceased for not taking suitable precautions while doing hazardous work.

2. On March 7, 1933, at 11:00 a.m., a colored miner, 62 years old, received injuries that proved fatal 4 days later. He was married and had six dependents. While the deceased was working at the face of an entry, draw rock 4 feet square and 14 inches thick, not timbered, fell on him, crushing his body and injuring him internally.

Responsibility for this accident rests on the deceased for not setting timbers for his own protection and also on laxity of supervision.

3. On May 13, 1933, at 11:30 a.m., a white timber and rock man, 52 years old, was killed by a rock fall. He was married and had five dependents. While the deceased and his helper were scaling the entry, the roof began "chipping", and the timberman started sounding the roof, beginning at the edge and going under the rock; a piece of it 5 feet square and 6 inches thick fell on him.

Responsibility for this accident rests on the deceased, who was experienced and in charge of the work, for not protecting himself.

4. On May 29, 1933, at 1:20 p.m., a colored miner, 33 years old, was killed on a wall by a rock fall. He was single and had no dependents. While he was loading coal at the face, draw rock 5 feet long, 1-1/2 feet wide, and 8 inches thick broke flush with the coal face and fell on him, crushing his head and chest. The place was timbered to within 4 feet of the face.

Responsibility was not placed, and the accident might well be classed as a "trade-risk".

5. On June 2, 1933, at 8:45 a.m., a white fireboss, 58 years old, was killed by a rock fall that crushed his head and body. He was married and had five dependents. After shooting in a heading the deceased, on his way to examine the room face at a room neck, was caught under a fall 20 feet long, 9 feet wide, and 16 inches thick 10 feet outby the face. This rock was known to be "drummy" and was not timbered.

Responsibility for this accident rests on the mine foreman for not having the rock taken down or timbered, on the miner for not cautioning the fireboss, and on the deceased for not testing the roof, which was one of his duties.

6. On July 20, 1933, at 4:00 p.m., a colored miner, 49 years old, received a fractured pelvis when draw rock 3 feet long, 2-1/2 feet wide, and 4 inches thick fell at the face of a room. He was married and had two dependents. The injury proved fatal 9 days later. The roof was tender, and a previous inspection report recommended closer timbering and supervision.

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Responsibility for this fatality rests on the company for not providing adequate inspection and on the deceased for not setting the necessary timbers to protect himself.

7. On August 3, 1933, at 11:30 p.m., a colored utility man, 25 years old, was killed by a rock fall that crushed his skull. He was single and had no dependents. The deceased was taking down loose rock on the entry when rock 14 feet long, 6 feet wide, and 5 feet thick fell, catching him. The rock had 3 posts under it and a slip on the rib, but when it came loose, it "rode" the 3 posts, and congestion in the entry prevented the deceased from escaping.

Responsibility for this fatality rests on the deceased and on the night-crew leader for not taking the proper safety precautions, when doing work known to be hazardous.

8. On August 31, 1933, at 11:00 a.m., a colored miner, 47 years old, received internal injuries from which he died a few hours later. He was married and had two dependents. Three men were slabbing a pillar, and the deceased was throwing back parting rock, when a rock 5 feet long, 2-1/2 feet wide, and 4 inches thick fell from the roof, a distance of 7 feet, and crushed him.

Responsibility for this fatality rests on the deceased for not testing, taking down, or timbering rock under which he was working.

9. On November 27, 1933, at 3:00 p.m., a colored miner, 57 years old, was killed by a rock 5 feet long, 3-1/2 feet wide, and 15 inches thick, which fell while he was working under tender roof with numerous slips in a poorly timbered room. He was married but had no dependents.

Responsibility for this fatality rests on the company for not requiring proper timbering and on the deceased for not setting the timbers necessary to protect himself.

10. On December 18, 1933, at 2:30 p.m., a white miner, 45 years old, was killed by a fall of rock that fractured his pelvis and punctured his bladder. He was married but had no dependents. The deceased was working in a room driven in 38 feet with only 3 timbers in it, under top known to carry "rolls", when a roll 21 feet long, 3 feet wide, and 4 inches thick fell, crushing his body.

Responsibility rests on the deceased for not setting timbers to protect himself and on the mine foreman for neglecting his supervisory duty in visiting working places and having them kept well-timbered.

Haulage

1. On January 11, 1933, at 5:30 a.m., a colored scraper, 28 years old, received a fractured spine and internal injuries that resulted in death the

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following day. He was married and had two dependents. The deceased was sitting on top of the end of a car about midway the trip on a man trip going up a 25° slope. His head struck an overcast 4-1/2 feet above the rail and 2 feet above the car end. Sitting on top of the car was a violation of a mine rule requiring men riding man trips to sit down inside the car.

Responsibility for this fatality rests on the deceased for violation of the mine rule and on the night foreman for not requiring compliance with the rule.

2 and 3. On June 30, 1933, at 6:45 a.m., two colored miners, one 29 and the other 49 years old, were killed, their bodies being crushed from waist to head by a collision between a man trip and an empty trip on the main entry. They were married the one having four dependents, and the other one. The man trip had just started in the mine on a level track, when a locomotive with empty cars, coming down a 4-percent grade, ran into it at a switch 350 feet from the portal, derailing three cars of the man trip and killing the two men.

Responsibility for this accident rests on the haulage-trip motorman, who lost control of his trip and ran into the man trip.

4. On July 18, 1933, at 8 a.m., a colored miner, 29 years old, was killed when a falling prop fractured his skull. He was single and had no dependents. A derailed car knocked down a prop, which struck the deceased on the head. The grade was 10 percent in favor of the loads when a car with two wheels spragged came out of a room, derailed, and knocked out the prop.

Responsibility for this accident was not placed, but it was probably due to faulty blocking or handling of the room car.

5. On July 22, 1933, at 5:40 a.m., a colored coupler, 42 years old, was killed when his body was crushed between a moving trip and entry timbers in front of the substation on the entry. He was married and had three dependents. A fall threw the circuit breaker out, and the deceased went outby on the entry, put the switch in, and was waiting for a loaded trip. While sitting on or leaning against the front timber wall of the substation, he was crushed between the pushed trip and the timbers (there was 8 inches clearance between trip and timbers) as the trip passed him.

Responsibility for this fatality rests on the company for the inadequate clearance and the pushed trip, and on the deceased for not watching for the trip and keeping in a safe place while it passed.

6. On August 7, 1933, at 7:45 a.m., a colored miner, 50 years old, received injuries that proved fatal 3 days later. He was married and had no dependents. While the deceased and his "buddy" were switching two empty cars by hand from the entry to the room, the former was crushed between the rib and a car (10 inches clearance) and his pelvis fractured.

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Responsibility for this fatality rests on the deceased for pushing the car from the side where the clearance was inadequate (the clearance on the opposite side was adequate) and on the company for not providing adequate clearance.

7. On September 25, 1933, at 11 a.m., a white laborer, 21 years old, received injuries that caused his death 2 days later. He was single and had no dependents. The deceased fell in front of a moving trip that crushed his body; he was standing in a safe place, when for some unknown reason he decided to cross the track in front of the approaching trip; realizing that he did not have clearance on the opposite side, he ran ahead of the trip along the entry and fell, and the cars ran on him.

Responsibility for this fatality rests on the deceased for not staying in a safe place until the trip had passed.

Electricity

1. On June 5, 1933, at 9:15 p.m., a white machine runner, 30 years old, was electrocuted. He was married and had three dependents. The deceased, wet with perspiration, ran the machine on which he was riding into a room neck; and as the machine stopped, his head struck the trolley wire or his leg came in contact with a bare place in the machine cable. The wire was 3 feet 8 inches above and directly over rail and 19 inches above the machine.

Responsibility for this accident rests on the company for not raising or shielding a low trolley wire and on the deceased for not safeguarding himself.

2. On June 15, 1933, at 2:50 p.m., a colored laborer, 23 years old, was electrocuted. He was single and had no dependents. A 24-volt signal wire "shorted" with a 220-volt alternating-current line. Working as a laborer on an inside slope, the deceased was removing equipment and had given a signal to hoist several times; he was again attempting to give the hoist signal when he was electrocuted by the signal wire. Artificial respiration was given for 2 hours, without success.

Responsibility for this accident was not placed, and it was classed as a "trade-risk", though it is probable that the shortcircuiting of the 220-volt wires and the signal wires was due to poorly placed wiring.

3. On August 15, 1933, at 6:40 p.m., a white motorman, 26 years old, was electrocuted on the main haulage when his head came in contact with the trolley wire carrying 250 volts direct current. He was married and had one dependent. While the motorman was turning the trolley pole from the deck pan of a locmotive, his hand slipped from the pole, and he lost his balance and fell against the wire. The wire was 50 inches above the rail and was not shielded.

Responsibility for this fatality rests on the company for allowing low and unshielded trolley wire and on the deceased for not taking the proper precautions in turning the pole.

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4. On December 19, 1933, at 4:10 p.m., a white miner, 21 years old, was electrocuted by a 2,300-volt alternating current. He was single and had no dependents. Upon leaving the mine, the deceased asked the surface hoisting engineer for his coat, which was on the guard rail around the switch panel. The hoisting engineer was busy at the time and said, "Wait a minute," but the deceased came in, got his coat, and in throwing it over his shoulder, struck the bus bars.

Responsibility for this accident rests on the deceased for entering the hoist house and on the hoisting engineer for keeping and hanging clothes near 2,300-volt conductors.

Gas and Dust

1. On August 11, 1933, at 9:30 a.m., a colored miner, 19 years old, received burns on the face, neck, arms, and legs, that caused death 24 hours later. He was single and had no dependents. The gas was ignited at the face of an idle room by an open light. The deceased was pulling a rail in a room that had not been worked for 2 weeks; it was 75 feet ahead of air and had been "marked out" for gas on May 19 but was "OK" the last day it was worked. A fall displaced a line curtain after the room was stopped, and the deceased passed over a danger board to get into the room.

Responsibility for this fatality rests on the deceased for going over a danger board and on the company for failure to have the fireboss examine a room adjacent to a working room and for allowing the use of open lights in a coal mine, especially one known to give off explosive gas.

Fatalities in 1934

In the production of 9,600,792 tons of coal in 1934, 32 fatalities resulted from the following causes: Falls of roof and coal, 14; haulage, 11; electricity, 3; gas and dust, 2; explosives, 1; and miscellaneous, 1.

Falls of Roof and Coal

1. On January 25, 1934, at 10:20 p.m., a colored miner, 24 years old, was killed by a rock 6 feet long, 2 feet wide, and 8 inches thick that crushed his skull. He was married and had three dependents. The slope entry roof had been brushed, but the slant in which the miner was working had not. The section foreman tested the roof an hour before the accident and considered it safe to work under.

Responsibility for this fatality rests on the company for not requiring closer inspection, proper roof testing, and adequate timbering.

2. On February 9, 1934, at 9:00 a.m., a white miner, 55 years old, was fatally injured on the slope face by a rock 3 feet 8 inches long, 2 feet 8 inches wide, and 10 inches thick that fell on him, breaking his back and causing his death 5 days later. He was married and had one dependent. The

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deceased and his fellow-workman, who were driving a slope, had set a row of breaking timbers for a top rock shot; after the two men finished shooting, they removed the timbers but delayed scaling or taking down rock they knew was loose.

Responsibility for this fatality rests on the deceased and his fellow-workman for working under rock they knew was loose.

3. On March 27, 1934, at 3:00 p.m., a colored miner, 59 years old, received internal injuries and died 4 days later. He was married but had no dependents. The deceased left his working place and went into another to get a shot-firing cable; when he was 60 feet from the face of the visited place, coal fell from the rib, breaking his left arm and rib; the injuries, complicated by pneumonia, resulted in death 4 days later.

Responsibility for this accident rests upon the deceased for not traveling the roadway.

4. On April 13, 1934, at 2:00 p.m., a white miner, 25 years old, was killed by a fall of rock. He was married and had two dependents. The deceased was slabbing an entry pillar; the shot "pulled" the coal rib but failed to "pull" draw rock; he returned and was using a pick on the coal when draw rock 3 feet thick fell on him, crushing his body.

Responsibility for this fatality rests on the deceased for not testing, taking down, or timbering the draw rock.

5. On April 30, 1934, at 8:00 a.m., a white brattice track and safety man, 52 years old, was killed when rock 12 feet long, 6 feet wide, and 8 inches thick fell, knocking a mine prop against him. He was married and had four dependents. The deceased was taking down loose rock at the face of a room that had been idle for 2 weeks, so work could be started in the room; when a timber was knocked out the rock fell, throwing the timber against the deceased.

Responsibility for this fatality rests on the deceased for not taking the proper precautions in doing hazardous work.

6. On May 31, 1934, at 12:10 p.m., a colored miner, 22 years old, was killed by a fall of rock. He was married and had two dependents. The deceased and a fellow-workman were barring down draw rock at the face of an entry when a piece of rock 13 feet long, 7 feet wide, and 1 foot thick fell and caught one of the men, crushing his skull.

The draw rock was not timbered; the responsibility for this accident rests on the deceased and his fellow-workman for not using the proper precautions when taking down loose roof and on the company for not providing closer inspection.

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7. On June 12, 1934, at 5:15 p.m., a colored scraper, 24 years old, was killed by a fall of rock that injured him internally. He was married (divorced) and had two dependents. To get the machine to a coal face in an air course, two or three posts had to be removed and reset after the machine passed. When the timbers were reset, they were not out in their respective or proper places, and while the machine was cutting the place, a "roll" or "horseback" 16 feet long, 3-1/2 feet wide, and 15 inches thick fell on the scraper. The shift leader tested the roll after the timbers were set and considered it safe, but a slip not supported by the reset timbers was revealed by the fall.

Responsibility for this fatality rests on the shift leader for not properly testing the roof and on the company for not providing proper inspection.

8. On July 25, 1934, at 12:30 a.m., a colored laborer, 30 years old, was killed by a fall of rock. He was married and had three dependants. The deceased was helping to move a conveyor to the face on a "wall" when rock 11 feet long, 5 feet wide, and 9 inches thick fell on him, crushing his body. The foreman, who was setting a post under loose rock, called the deceased to bring a cap board; as he was delivering it, the rock under which he was passing fell on him.

Responsibility for this accident rests on the foreman for not moving the conveyor between timbers and for allowing the laborer to travel under loose rock.

9. On July 30, 1934, at 3:00 a.m., a white utility man, 30 years old, was killed by a rock fall. He was married and had three dependents. The deceased was drilling a roadway bottom 15 feet from the face of a room when rock 10 feet long, 5 feet wide, and 1-1/2 inches thick fell on him, crushing his body. The roof was known to be weak, and it sounded "drummy" when the deceased tested it, but he went on drilling without taking it down or timbering it.

Responsibility for this accident rests on the machine runner (in charge of the crew) for not properly testing and making the roof safe, and the victim certainly shares definite responsibility for failing to protect himself adequately.

10. On August 1, 1934, at 2:30 p.m., a white miner, 22 years old, was killed when rock 7-1/2 feet long, 5 feet wide and 6 inches thick fell on him. He was married but had no dependents. Face coal had been shot, roof tested and found loose, and an attempt made to bar the rock down; failing in the attempt, the deceased began loading coal without timbering, and the rock fell on him, breaking his neck; this is a far too usual type of accident.

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Responsibility for this accident rests on the deceased and his fellow-workman for not properly protecting themselves and on the company for not enforcing the use of safety timbers; if the rock is suspected of being loose, through sound or appearance, and it fails to come down by barring, it should then be supported by timber, otherwise it is likely to fall at any time.

11. On August 21, 1934, at 10:30 p.m., a colored miner, 31 years old, was killed at the face of an entry by a fall of rock 11 feet long, 6 feet wide, and 5 inches thick that crushed his body and head. He was single and had no dependents. Four men were driving an entry and air course; two were turning coal, and two were loading it in a car. There were three timbers under the rock which fell - one under the center and two under the edge.

Responsibility for this fatality rests on the deceased and his fellow-workmen for not taking down or properly timbering rock before working under it.

12. On September 8, 1934, at 10:30 a.m., a white miner, 22 years old, was killed at the face of a room by a fall of rock 19 feet long, 8 feet wide, and 5 inches thick that broke his back. He was single and had no dependents. Since the mine has a timber rule of 4-foot centers, the section foreman visited the place and called attention to the fact that required timbers must be set. The timbers had been delivered and unloaded, and the deceased and his "buddy" were loading coal in the car, from which they had unloaded the timbers, when the rock fell.

Responsibility rests on the deceased for not protecting himself and on the foreman for not stopping the loading of coal in the place until timbers were set.

13. On September 20, 1934, at 2:30 p.m., a colored miner, 55 years old, was killed at the face of an entry by a fall of rock 7 feet long, 3 feet wide, and 6 inches thick that broke his neck. He was married but had no dependents. The deceased was undercutting coal with a pick; although it was known that the roof carried "slips" and a supply of timbers was on hand, the roof was not properly supported. The slip that allowed the rock to fall was hidden by the coal.

This accident was classed as a "trade-risk", but it might well be ascribed to failure to have a rigid timbering rule in a mine in which hidden slips are known to occur.

14. On November 17, 1934, at 1:50 p.m., a white motorman, 29 years old, received internal injuries in a rock fall that caused death a few days later. He was married but had no dependents. A rock 14 feet long, 6 feet wide, and 4 inches thick fell on him from the roof over a room roadway. After the deceased had placed a car in a room for loading and was going back to the entry with the locomotive, a rock over the roadway fell, causing the accident.

Responsibility for this accident rests on the company for not maintaining roadways in safe condition.

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Haulage

1. On January 24, 1934, at 3:30 p.m., a colored motorman, 33 years old, received a broken neck when he was struck by a trolley pole. He was married and had two dependents. The trolley pole broke while it was being turned with the locomotive in motion on the entry. The wheel caught in the roof, and a 2-1/2-foot section broke from the wheel, striking the motorman on the head.

Responsibility for this fatality rests on the deceased for violating a mine rule and a safe practice by turning the pole with the locomotive in motion.

2. On February 21, 1934, at 3:25, p.m., a white rollerman (main slope) was killed by a derailed slope trip that broke and ran down the slope, catching the victim and crushing his entire body. He was married but had no dependents. A lump of coal in a 14° rock slope 14 feet wide and 8 feet between track and rib derailed an empty trip, which caught the deceased and brushed him against the rib. The slope had no shelter holes.

Responsibility for this fatality rests on the deceased for not protecting himself and on the company for not providing proper shelter holes.

3. On April 25, 1934, at 3:10 p.m., a white miner, 25 years old, was killed in a haulage accident. He was single and had no dependents. The deceased and two other men were riding on a loaded trip up a 35° slope; when the trip was near the mine entrance the pin between the second and third car came out, allowing three cars on which the men were riding to run back down the slope. When the drag derailed the cars the three men jumped, and the deceased was crushed between the cars and the rib. Before the trip started the chainer ordered the men to get off, but they refused to do so.

Responsibility rests with the deceased for violation of the State mining law and on the chainer for signaling the hoistman to pull a trip with men on it.

4. On May 3, 1934, at 11:00 p.m., a colored driver, 22 years old, was killed when a moving car crushed his body. He was single and had no dependents. The deceased crawled over a moving car and fell in front of it. The driver, with a mule and one loaded car, was riding on the rear bumper over undulating track on the entry; in crossing over the car to place sprags, he fell under the car.

Responsibility for this accident was not placed, but it might well be classed as a "trade-risk," as an occasional accident of this type is very difficult to avoid.

5. On May 16, 1934, at 10:00 a.m., a colored motorman, 32 years old, was killed on a haulage accident. He was married and had two dependents. The coupler pushing a trip on main haulage latched a mine ventilation door open, but it unlatched and closed, derailing the locomotive and crushing the motorman.

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Responsibility for this fatality rests on the deceased for operating a locomotive at excessive speed and on the company for allowing doors to be latched instead of held open; latching of doors (open) has been responsible for numerous explosions due to interruption of ventilation when the door remained open too long.

6. On May 28, 1934, at 5:00 p.m., a white coupler, 23 years old, was killed when a trip of empty cars ran over him, breaking his back and crushing his body. He was single and had no dependents. The deceased was running in front of a trip of empty cars on the main haulage, making a "flying switch", when he fell and was run over.

Responsibility for this fatality rests upon the company for allowing a coupler to make "flying switches" which required him to run beside or in front of the cars.

7. On September 7, 1934, at 1:00 p.m., a white motorman (coupler), 40 years old, was killed when he fell under a moving locomotive on main haulage. He was married and had six dependents. The regular coupler had been injured, the transportation boss was operating the locomotive, and the motorman (deceased) was acting as a coupler when he fell or was knocked off the front end of the locomotive of a pushed trip of 12 cars and his body was crushed.

Responsibility for this fatality rests on the motorman (coupler) for taking chances and on the company for not providing adequate clearance and for allowing the pushing of trips.

8. On October 22, 1934, at 2:30 p.m., a colored driver, 42 years old, was killed when he was caught between two loaded coal cars. He was a widower and had two dependents. The deceased was riding the front end of a two-car trip and ran into another two-car trip at a room-and-entry switch. The rule to stop the trip before coming out on the entry had been violated.

Responsibility for this fatality rests on the deceased for violating the mine rule in not stopping the trip before coming out of a room on the entry.

9. On November 1, 1934, at 3:00 p.m., a colored miner, 41 years old, was killed by a blow on the head that fractured his skull. He was married and had one dependent. The deceased and his "buddy" were handling a post over a loaded car in a room when the car scotches were knocked out; the car, standing on a 7° grade with the deceased on top, ran 100 feet and was wrecked; the deceased's skull was fractured against a cross collar.

Responsibility for this fatality rests on the deceased for not blocking the car for his own protection and on the company for not requiring secure blocking of cars on 7° grades.

10. On November 7, 1934, at 2:10 p.m., a white haulage foreman, 53 years old, was killed when a main haulage locomotive ran over him, crushing his body. He was a widower with no dependents. While hauling an injured

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man to the side-track on a stretcher on top of a locomotive, the deceased, who was holding the injured man's bleeding head, fell in front of the locomotive and was run over. The assumption is that he fainted, and the accident is classed as unavoidable.

11. On December 28, 1934, at 2:00 p.m., a colored coupler, 34 years old, was killed in an accident on the main haulage. He was single and had no dependents. A small rock-fall on the track derailed the locomotive, knocking out timbers and allowing 100 tons of rock to fall on the locomotive and coupler, breaking the coupler's neck. The top was weak, and the timbers were in bad condition.

Responsibility for this accident rests on the company for not keeping the haulage in safe operating condition.

Electricity

1. On August 16, 1934, at 2:15 p.m., a white miner, 20 years old, was electrocuted by coming in contact with a 250-volt direct-current wire. He was single and had no dependents. The deceased was moving tools around standing cars on the entry under the trolley wire to the man-trip loading place; there was a 15-inch clearance between the cars and rib. An auger touched the wire while the deceased's hands were on a car.

Responsibility for this fatality rests on the company for not providing sufficient clearance and on the deceased for not taking proper precautions to protect himself.

2. On September 21, 1934, at 9:00 a.m., a white miner, 23 years old, was electrocuted. He was married and had one dependent. The deceased's shoulder came in contact with a 250-volt direct-current trolley wire. A car was derailed at the frog while being pushed out of a room; the deceased was helping his fellow-workman to rerail it when he came in contact with the wire. Artificial respiration was given for 1 hour without success. The wire was 46 inches above the rail and unshielded.

Responsibility for this accident rests on the company for low and unshielded trolley wire.

3. On December 26, 1934, at 1:30 p.m., a white coupler, 34 years old, was electrocuted when he came in contact with a 250-volt direct-current trolley wire on the main entry. He was married and had one dependent. While riding on the deck of a locomotive the deceased arose to throw two picks off while the trip was moving and failed to sit down in time to avoid striking his shoulder against the wire at a low point in the roof.

Responsibility for this accident rests chiefly on the company for not properly suspending and shielding the trolley wire; the victim also was at fault in rising to throw picks from a moving locomotive.

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Gas and Dust

1 and 2. On January 9, 1934, at 12:15 a.m., two colored miners were killed in a gas ignition. One was burned from the waistline up. He was married but had no dependents. The other man was single and had no dependents. Gas ignited in a wide room by a nonpermissible electric drill burned five men, two of whom died.

Responsibility for this accident rests on the foreman and on the night foreman for allowing men to work without proper air and for failure to detect methane, and on the company for not requiring adequate ventilation, and for using nonpermissible electrical equipment.

Explosives

1. On March 7, 1934, at 4:00 p.m., a white miner, a shift leader, 23 years old, was killed when flying coal and rock from a shot crushed his skull. He was married but had no dependents. The deceased prepared the charge, loaded the hole, and lighted the fuse and started away but left his pick; he returned to the wall face to get the pick, and when he was 10 feet away the shot went off.

Responsibility rests on the deceased for failure to exercise safe and sane judgment.

Miscellaneous

1. Surface: On October 30, 1934, at 8:30 a.m., a white utility man, 30 years old, was killed when a tipple collapsed. He was divorced and had no dependents. The deceased and a mine foreman were dumping coal in a 90-ton bin; when it had about 45 tons in it, the tipple fell. The 10- by 10-inch timbers were 30 percent decayed; this was the last day the tipple was to be used, and the last car of coal to be dumped.

Responsibility for this fatality rests on the company for allowing an insecure tipple structure to be used.

Tabulation of Data

The data on fatal accidents for the 4-year period are further condensed in table 2 according to occupation, race, age, dependents, day or night shift, and nature and cause of and responsibility for the accidents.

Under "Responsibility", "Company" includes management and operating practices and general supervision, except where an individual supervisor is responsible, in which case "shift leader," "foreman," or a similar term is used.

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TABLE 2. - Alabama coal-mine accidents, 1931-34

Date	Occupation	Race	Age	Dependents	Time of day	Nature of injury	Cause of accident 1/	Responsibility
1931, Jan. 7	Miner	Negro	44	0	Day	Fractured skull	Falls	Deceased, foreman, and company.
Jan. 14	Carpenter	White	52	2	do.	Fractured leg and ribs	Moving machinery	Foreman, deceased.
Feb. 13	Miner	Negro	50	0	do.	Crushed	Falls	Do.
Mar. 13	Coupler	do.	24	0	do.	Fractured legs	Haulage	Motorman.
Mar. 16	Miner	do.	42	0	do.	Fractured pelvis and leg	do.	Foreman, deceased.
Apr. 6	Shot firer	do.	18	0	do.	Mangled	Explosives	Company
May 22	Driver	do.	35	1	do.	Crushed body	Haulage	Company, deceased.
May 25	Motorman	do.	32	0	do.	do.	do.	Deceased.
May 31	Shift leader	White	45	2	Night	Fractured spine	do.	Do.
June 24	Laborer	Negro	52	0	Day	Crushed body	Rock fall	Foreman, contractor.
July 3	Miner	do.	38	4	Night	Internal injuries	Falls	Deceased, section foreman.
July 16	Laborer	do.	37	2	Day	do.	Haulage	Deceased, company.
July 17	Coupler	White	22	0	do.	Fractured skull	do.	Company.
Aug. 18	Hoistman	do.	22	0	do.	Right arm torn	Machinery	Deceased.
Aug. 25	Entry foreman	do.	26	1	do.	Broken back	Falls	Company.
Sept. 8	Motorman	do.	28	1	do.	Legs crushed	Haulage	Do.
Sept. 28	Miner	Negro	29	0	do.	Fractured pelvis	do.	Foreman, fellow-workman.
Oct. 14	Do.	do.	33	1	do.	Fractured skull	Falls	Company, deceased.
Nov. 11	Laborer	do.	36	1	do.	Electrocuted	Electricity	Do.
Dec. 11	Do.	do.	47	0	do.	do.	do.	Company.
Dec. 21	Drag loader	do.	25	1	do.	Crushed body	Falls	Do.
Dec. 24	Laborer	do.	25	0	do.	Burns	Gas and dust	Company, foreman.
Dec. 29	Do.	do.	36	1	do.	do.	do.	Do.
Dec. 29	Do.	do.	25	1	do.	do.	do.	Do.
--	Miner	do.	--	-	do.	--	Miscellaneous	Not placed.
--	Do.	do.	--	-	Night	--	do.	Do.

1/ Haulage, 9; falls of rock and coal, 7; electricity, 2; gas and dust, 3; machinery, 2; miscellaneous, 2; explosives, 1; total, 26.

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TABLE 2. - Alabama coal-mine accidents, 1931-34 - continued.

Date	Occupation	Race	Age	Dependents	Time of day	Nature of injury	Cause of accident 1/	Responsibility
1932, Jan. 13	Coupler	Negro	31	4	Day	Electrocuted	Electricity	Deceased, company.
Jan. 22	Miner	White	22	0	do.	Fractured skull	Falls	Do.
Feb. 3	Do.	Negro	27	1	do.	Crushed body	do.	Deceased, foreman
Feb. 22	Do	do.	35	7	do.	do.	do.	Deceased.
Apr. 14	Chute rider	White	24	0	do.	Fractured skull and broken neck	do.	Company.
Apr. 22	Scraper	do.	24	0	Night	Electrocuted	Electricity	Do.
Apr. 26	Shift leader	do.	25	0	Day	Body crushed	Falls	Do.
May 23	Coupler	Negro	24	1	Night	Electrocuted	Electricity	Do.
June 25	Boss driver	White	31	2	Day	Fractured skull	Falls	Deceased, company.
Sept.13	Scraper	do.	24	0	Night	do.	do.	Company, shift leader.
Sept.18	Miner	Negro	66	0	Day	Fractured skull and crushed body	do.	Company.
Nov. 15	Foreman	White	42	3	Night	Fractured skull	do.	Deceased.
Nov. 17	Miner	do.	19	0	Day	Crushed body	do.	Foreman.
Nov. 28	Do.	do.	32	2	do.	Fractured skull	Haulage	Fellow-workman, foreman.
Dec. 4	Contractor	do.	24	0	do.	Fractured skull and crushed body	Falls	Company, deceased.
Dec. 13	Miner	Negro	--	-	do.	Electrocuted	Electricity	Deceased.
Dec. 23	Timber-helper	do.	30	0	do.	Fractured skull and crushed body	Falls	Timberman, deceased.
Dec. --	Coupler	do.	--	-	do.	Fractured leg and internal injuries	Haulage	Not placed.

1/ Falls of roof and coal, 12; electricity, 4; and haulage, 2.

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TABLE 2. - Alabama coal-mine accidents, 1931-34 - continued.

Date	Occupation	Race	Age	Dependents	Time of day	Nature of injury	Cause of accident 1/	Responsibility
1933, Jan. 11	Scraper	Negro	28	2	Night	Fractured back	Haulage	Deceased, foreman.
Jan. 18	Trackman	White	40	4	do.	Head and body crushed	Falls	Do.
Mar. 7	Miner	Negro	62	6	Day	Crushed body	do.	Deceased, company.
May. 13	Timber and rockman	White	52	5	do.	Fractured skull	do.	Deceased.
May 29	Miner	Negro	33	0	do.	Crushed head and body	do.	Not placed.
June 2	Fireboss	White	58	5	do.	do.	do.	Foreman, fellow-workman, deceased.
June 5	Machine runner	do.	30	3	Night	Electrocuted	Electricity	Company, deceased.
June 15	Laborer	Negro	23	0	Day	do.	do.	Not placed.
June 30	Miner	do.	49	1	Night	Crushed head and body	Haulage	Motorman.
June 30	Do.	do.	29	4	Day	do.	do.	Do.
July 18	Do.	do.	29	0	do.	Fractured skull	do.	Not placed.
July 20	Do.	do.	49	2	do.	Fractured pelvis	Falls	Company, deceased.
July 22	Coupler	do.	42	3	Night	Crushed body	Haulage	Do.
Aug. 3	Utility man	do.	25	0	do.	Fractured skull	Falls	Deceased.
Aug. 7	Miner	do.	50	0	Day	Fractured pelvis	Haulage	Deceased, company.
Aug. 11	Do.	do.	19	0	do.	Burns	Gas and dust	Do.
Aug. 15	Motorman	White	26	1	Night	Electrocuted	Electricity	Company, deceased.
Aug. 31	Miner	Negro	47	2	Day	Internal injuries	Falls	Deceased.
Sept. 25	Laborer	White	21	0	do.	Body crushed	Haulage	Do.
Nov. 27	Miner	Negro	57	0	do.	do.	Falls	Company, deceased.
Dec. 18	Do.	White	45	0	do.	Fractured pelvis	do.	Deceased.
Dec. 19	Do.	do.	21	0	do.	Electrocuted	Electricity	Deceased, hoisting engineer.

1/ Falls of roof and coal, 10; haulage, 7; electricity, 4; and gas and dust, 1.

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TABLE 2. - Alabama coal-mine accidents, 1931-34 - continued.

Date	Occupation	Race	Age	Dependents	Time of day	Nature of injury	Cause of accident[1]	Responsibility
1934, Jan. 9	Miner	Negro	—	0	Night	Burns	Gas and dust	Foreman.
Jan. 9	Do.	do.	--	0	do.	do.	do.	Do.
Jan. 24	Motorman	do.	—	2	Day	Fractured spine	Haulage	Deceased.
Jan. 25	Miner	do.	24	3	Night	Crushed skull	Falls	Company.
Feb. 9	Do.	White	55	1	Day	Fractured spine	do.	Deceased, fellow-workman.
Feb. 21	Rollerman	do.	—	0	do.	Crushed head and body	Haulage	Deceased, company.
Mar. 7	Shift leader	do.	23	0	do.	Fractured skull	Explosives	Deceased.
Mar. 27	Miner	Negro	59	0	do.	Internal injury	Falls	Do.
Apr. 13	Do.	White	25	2	do.	Crushed body	do.	Do.
Apr. 25	Do.	do.	35	0	do.	do.	Haulage	Deceased, fellow-workman.
Apr. 30	Track, safety and bratticeman	do.	52	4	do.	Internal injury	Falls	Deceased.
May 3	Driver	Negro	22	0	Night	Crushed body	Haulage	Not placed.
May 16	Motorman	do.	32	2	Day	do.	do.	Deceased, company.
May 28	Coupler	White	23	0	Night	Fractured back and crushed body	do.	Company.
May 31	Miner	Negro	22	2	Day	Fractured skull	Falls	Deceased, fellow-workman.
June 12	Scraper	do.	24	2	Night	Internal injury	do.	Shift-leader, company.
July 25	Laborer	do.	30	3	do.	Crushed body	do.	Foreman.
July 30	Utilityman	White	30	3	do.	do.	do.	Machine runner and foreman.
Aug. 1	Miner	do.	22	0	do.	Fractured spine	do.	Deceased, company.
Aug. 16	Do.	do.	20	0	Day	Electrocuted	Electricity	Company, deceased.
Aug. 21	Do.	Negro	31	0	Night	Body and head crushed	Falls	Deceased, fellow-workman.
Sept. 7	Motorman (coupler)	White	40	6	Day	Crushed body	Haulage	Company.
Sept. 8	Miner	do.	22	0	do.	Fractured spine	Falls	Deceased, foreman.

1/ Falls of roof and coal, 14; haulage, 11; electricity, 3; gas and dust, 2; explosive, 1; and miscellaneous 1.

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TABLE 2. - Alabama coal-mine accidents, 1931-34 - continued.

Date	Occupation	Race	Age	Dependents	Time of day	Nature of injury	Cause of accident[1/]	Responsibility
1934, Sept. 20	Miner	Negro	55	0	Day	Fractured spine	Falls	Not placed.
Sept. 21	Do.	White	23	1	do.	Electrocuted	Electricity	Company.
Oct. 22	Driver	Negro	42	2	do.	Internal injury	Haulage	Deceased.
Oct. 30	Utilityman	White	30	0	do.	do.	Miscellaneous	Company.
Nov. 1	Miner	Negro	41	1	do.	Fractured skull	Haulage	Deceased, company.
Nov. 7	Haulage foreman	White	53	0	do.	Body crushed	do.	Not placed.
Nov. 17	Motorman	do.	29	0	do.	Internal injury	Falls	Company.
Dec. 26	Coupler	do.	34	1	do.	Electrocuted	Electricity	Do.
Dec. 28	Do.	Negro	34	0	do.	Fractured spine	Haulage	Do.

1/ See footnote page 28.

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Accident Responsibility

Responsibility was placed on both conditions and the individual miner or miners in 89 of the 98 fatal accidents, as indicated in table 3.

Where "Company" is used in this table, it includes management, operating practices, and general supervision, except where an individual supervisor is responsible, in which case "foreman" is used.

TABLE 3. - Alabama coal-mine accident responsibility, 1931-34

Deceased and company	21
Deceased	18
Company	18
Deceased and foreman	7
Foreman	6
Company and foreman	6
Deceased and fellow-workman	5
Fellow-workman	3
Fellow-workman and foreman	2
Foreman, fellow-workman, and deceased	1
Deceased, fellow-workman, and company	1
Fellow-workman and company	1
Responsibility not placed	9
	98

Relation of Accidents to Mines and Production

From 1931 to 1934, 98 fatalities occurred in 54 mines operated by 33 companies.

Table 4 shows fatalities on a production basis during the 4-year period.

Table 5 gives number of men employed, fatalities, and coal production by counties and years.

TABLE 4. - Mines, fatalities, and production, 1931-34

Production, tons	No. of mines	Total fatalities
1,000 to 15,000	7	7
15,001 to 100,000	2	2
100,001 to 300,000	8	24
300,001 to 600,000	18	37
600,001 to 1,000,000	7	12
1,000,001 to 2,000,000	12	16
	54	98

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TABLE 5. - Number of fatalities and employees and coal production in Alabama coal mines by counties and years

County	1931			1932			1933			1934		
	Fatalities	No. of employees	Coal production, tons	Fatalities	No. of employees	Coal production, tons	Fatalities	No. of employees	Coal production, tons	Fatalities	No. of employees	Coal production, tons
Bibb	2	1,075	549,865	3	926	405,428	5	1,102	479,840	0	1,178	499,299
Blount	0	578	163,421	1	489	231,189	0	196	118,240	0	335	112,750
Fayette	0	198	107,957	1	210	100,325	0	227	109,000[2]	1	208	120,770
Jefferson	19	11,186	6,060,583	7	10,635	3,517,083[1]	12	10,069	4,457,281	17	9,503	5,116,904
Marion	1	566	222,180	1	564	192,732	0	514	253,252	1	611	264,843
Shelby	1	1,093	537,116	1	1,011	371,041	3	1,094	483,332	5	993	491,920
St. Clair	1	988	759,131	0	868	504,650	0	961	478,449	3	1,133	599,963
Tuscaloosa	0	952	211,678	1	474	121,544	0	344	90,781	0	190	151,743
Walker	2	6,520	3,491,349	3	5,192	2,468,804[1]	5	4,418	2,267,140[3]	2	4,069	2,196,100
Other counties	0	132	23,002	0	93	17,896	0	123	14,421	0	86	51,500
State	26	3,288	12,126,282	18	20,462	7,930,692	22	19,048	8,751,736	32	18,306	9,605,792

1 1 mine missing.
2 Estimated.
3 2 mines missing.

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SUMMARY

Although the specific cause of each fatality is given for the 4-year period it may be of interest to discuss some of the most frequent contributory factors pertinent to the accidents.

Falls of roof and coal were responsible for 43 of the 98 fatal accidents; haulage for 29; electricity for 13; gas and dust for 6; explosives for 2; machinery for 2; and miscellaneous causes for 3.

Falls of Roof and Coal

The factors contributing primarily to the 43 fatal accidents caused by falls of roof and coal were determined to be as follows: Insufficient or improper timbering, 12; failure to test, or improper testing of roof, 6; failure to take down or have loose material taken down, 5; failure to place timbers for one's own protection, 5; "taking chances" or allowing unnecessary chances to be taken, 5; inadequate or improper supervision, 4; improper or infrequent inspection of haulage roof, 3; failure to enforce or comply with mine rules, 3; and improper timbers, 1.

Haulage

The contributing factors to the 29 haulage fatalities were, from the reports, as follows: Inadequate or insufficient clearance, 8; insecure spragging or blocking cars, 4; riding loaded slope trips, 2; pushed trips, 2; riding front end of locomotives, 2; excessive speed, 2; collisions, 2; flying switches, 2; turning trolley pole while locomotive was in motion, 1; crawling over moving trip, 1; fastening ventilation doors open, 1; bad track, 1; and walking main haulage, 1.

Electricity

Contributing causes to the 13 fatal electrical accidents were as follows: Low and unshielded wire at turnouts, 6; using trolley-wire side of entry for travel, 1; crawling over trip, 1; replacing trolley wheel on wire while locomotive was in motion, 1; wire not shielded at station, 1; water in entry, 1; short circuit between 24-volt bell wire and 220-volt power circuit, 1; and carrying tools on shoulder under wire, 1.

Gas and Dust

The six fatalities caused by gas and dust in the 4-year period had as primary contributing factors the following: Insufficient air and laxity in testing for methane and nonapproved mining machine, 2; inadequate air and carbide lamp, 1; and improperly conducted ventilation, laxity in testing for methane, and a nonpermissible mining machine, 3.

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CONCLUSION

Compared with other coal-mining States, Alabama had a favorable accident experience for the 4 years 1931-34.

Accidents in Alabama coal mines have been reduced, and can and very probably will be reduced further.

The investigation of accidents or near-accidents, a study of hazards and their safeguarding or elimination, proper training of every employee in the safe and efficient way to do his specific work, and a cooperative effort on the part of all concerned should result in the further material reduction of accidents in the coal mines of Alabama.

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